STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087153	A. BUILDING: _____ B. WING _____	09/19/2013

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ACCORD SENIOR CARE INC - ROCKWOOD	6807 E ROCKWOOD RD WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following citations are the result of Complaint investigations #65005, #68446, #68699, and #65089, at the above named Home Plus Facility in Wichita, Kansas on 9/03/13, 9/04/13, 9/05/13, 9/09/13, 9/10/13, 9/11/13, 9/12/13, 9/16/13, 9/17/13, 9/18/13, and 9/19/13.	S 000		
S 110 SS=F	26-39-103 (c) NOTICE OF RIGHTS AND SERVICES (c) Notice of rights and services. (1) Before admission, the administrator or operator shall ensure that each resident or the resident's legal representative is informed, both orally and in writing, of the following in a language the resident or the resident ' s legal representative understands: (A) The rights of the resident; (B) the rules governing resident conduct and responsibility; (C) the current rate for the level of care and services to be provided; and (D) if applicable, any additional fees that will be charged for optional services. (2) The administrator or operator shall ensure that each resident or the resident ' s legal representative is notified in writing of any changes in charges or services that occur after admission and at least 30 days before the effective date of the change. The changes shall not take place until notice is given, unless the change is due to a change in level of care. This STANDARD is not met as evidenced by: KAR 26-39-103(c) The census equalled five the sample included four current Residents with focused reviews	S 110		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S 110	Continued From page 1 completed on one current Resident and two discharged Residents. Based on interviews, and reviews of records, for all Residents admitted to facility, the Operator failed to ensure before admission, the Resident or the Resident's representative was informed both orally and in writing in a language they understand of the rights of the Resident, the rules, and the current rate for the level of care and services to be provided, and if applicable any additional fees charged for optional services. Findings included: - By confidential interview, an individual stated many misrepresentations and misunderstandings took place before and during the admission process of #7 and #8 to the facility. The individual described misunderstandings related to moving assistance, and transportation expectations, and money due (including deposits) at the time of admission. Individual stated admission agreements were provided on site by CMA (certified medication aide) #E at facility, after #7 and #8 were physically in their room... blanks were filled in for price after #E called Operator...informed a deposit due not mentioned before... check provided, agreements were signed, but information not very clear, and no copies of papers signed ever received... attempts to get grievances resolved failed... unable to contact Operator and issues not resolved by facility staff on duty. On 9/18/13, review of the facility admission agreements (Residential Rental Agreement) for #7 and #8 revealed: A "Billing and Charges" section page one, with blanks for the amount to be paid by Resident, no mention of deposits.	S 110		

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S 110	Continued From page 2 The Grievance Procedure section on page 6. This procedure directed Resident or responsible part to contact "management" regarding any grievance... if satisfactory solution cannot be reached Resident or responsible party may contact one of the "managing partners"... and if still not resolved a formal grievance shall be submitted to: a large blank space observed in this area of page 6, and an additional statement "Or by calling Kansas, then blank, then, Monday through Friday from 8:00 a.m. - 5:00 p.m. at, then a blank. By interview on 9/18/13 at 1:10pm Operator stated I do not have a grievance policy per say... they are to contact me... I am "management"... "managing partners?... that is me"... Staff is to fill out an incident report if there are complaints from family... that is not included in the admission agreement information... Operator confirmed the admission agreement contained blanks and was not complete. By interview on 9/18/13 at 1:48pm, Operator stated a family member of #7 and #8 toured facility while I was at the Operator course, and basic information was given to the family (verbally) at that time... I have a brochure and a basic price sheet that I share with prospective Residents... I have brochure here, do not have price sheet... it is on thumb drive in my home office... I do remember #7 and #8 were given a discount... I am not 100% sure of where deposits would be discussed in writing... By interview on 9/18/13 at 3:00pm, RN #A stated I do marketing for the facility... I gave all my printed price lists to hospitals and other entities when marketing this new company... I have brochures, but when it comes to money and finances I refer	S 110		

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S 110	Continued From page 3	S 110		

prospective Residents/families to the Operator... I can verbally tell them some basic information, then RAC/LPN #B sets up residential needs... as far as deposits, I refer all billing stuff to the Operator. At 3:45pm RN #A reported I do not have any printed price lists in my car... I know it's on my home computer... if family or Resident has cost questions I tell them to make a list and review with the Operator.

By interview on 9/18/13 at 3:45pm, Operator stated that kind of information on any other charges and costs besides room cost is on the NSA (negotiated service agreement) and the Admission Agreement.

By interview on 9/18/13 at 3:45pm, asked Operator for any documentation regarding the amounts paid at time #7 and #8 admitted to facility and if deposits included in that amount. Operator stated I will e-mail supporting documentation in the morning.

On 9/19/13 at 1:00pm, no additional information available to review. No evidence of written information provided to Resident and or Representative before admission to explain the rights, services, rates, and rules to Resident, and any other costs including deposits, that may be incurred. According to Operator and RN #A that information all provided verbally.

The Operator failed to ensure before admission, #7 and #8, or their representatives were informed both orally and in writing in a language they understand of the rights of the Residents, the rules, and the current rate for the level of care and services to be provided, and if applicable any additional fees charged for optional services. The Operator failed to develop and implement a policy

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S 110	Continued From page 4 and procedure for resolving of grievances.	S 110		
S5026 SS=G	26-42-101 (f) (1) Staff Treatment of residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(1) The census equalled five the sample included five current Residents. Based on observations, interviews, and reviews of records, for one of five sampled (Resident #2), the Operator failed to ensure that no resident was subjected to verbal, mental or physical abuse when Resident #2 subjected to repeated physical aggression and invasion of his/her room by resident #4. Resident #2 experienced pain and expressed fear. Findings included: Resident #2 admitted to facility 02/11/13 with diagnoses of Cerebral atrophy, Cerebral vascular disease, Depression, Hypertension, Osteoarthritis, Dyslipidemia, Incontinence, Dysphagia, and Renal Insufficiency. The 02/11/13 FCS (functional capacity screen) assessed #2 in	S5026		

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S5026	Continued From page 5 need of physical assistance with bathing, dressing, transfers, mobility; unable to perform toileting, medication and treatment management; with Incontinence; Falls/unsteadiness; Short term memory, recall, and impaired decision making. The NSA (negotiated service plan) stated services to address all the identified needs listed above provided by facility staff. By confidential interview on 9/05/13 an individual stated " I am aware that resident #4 started bothering resident #2 in March or April ... around tax time... #2 started sharing comments about #4 ... ' pushed me in my room, pushed me back in chair ' ... ' will stand by my bed and stare at me ' adding ' that scares me ' and ' I pretend I am asleep ' ... I know a family member told RAC (Resident assessment coordinator)/LPN #B to keep resident #4 away from resident #2.. on 8/14/13 #4 twisted #2's wrist... on 8/20/13 #4 pushed #2 by the TV, then went after CMA (Certified Medication Aide) #F... I know another staff CMA #G also got socked in the back. ' By confidential interview on 9/05/13 another individual stated I know resident #4 hit or shoved resident #2... " it got pretty bad, not too long ago. " By interview on 9/04/13 Resident #2 displayed great sincerity and used facial expressions and arm gestures to convey a great deal of his/her recollection ... when asked " Do you feel safe? Resident #2 replied " a little, I don ' t know, not much " ... " He/she hit me and bopped the nurse " ... Observed gestures of #2 as he/she patted own forearm while describing altercation with resident #4 at the table lamp ... observed	S5026		

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S5026	Continued From page 6 gestures as #2 patted and touched own wrist as described TV altercation with resident #4 ... observed resident #2 pat hip and knee, eyes wide, describing staff on floor " I was begging nurse please get up " (when staff intervened when Resident #4 grabbing resident #2 ' s wrists at the TV). Resident #2 also referred to a time when resident #4 pushed him/her back in chair but added " I didn ' t fall " . Resident #2 stated " I pretend to be asleep when #4 comes into my room... #4 has hurt my arm and has hurt the nurses who work here " ... #2 again described #4's assault and injury of staff... " #4 has taken things from my room... I have to stay quiet as I can when he/she comes to my room, he/she sits in a chair by me... " ... #2 made multiple hand demonstrations of placing personal belongings in pocket and under pillow at night " to keep them safe " ... and occasionally grabbed walker stating " I keep it close by so my things are safe " (walker has storage bag hanging on front with belongings inside). Resident #4 admitted to facility 4/03/13 with diagnoses of Dementia, Agitation, Psychosis, Parkinson's, Muscle spasms, Insomnia, and Status post pneumonia. The 4/03/13 FCS assessed resident #4 in need of physical assistance with bathing, unable to perform medication and treatment management; with Falls/unsteadiness, Impaired cognition and Impaired decision making. The 4/03/13 NSA stated services to address all the identified needs listed above provided by facility staff. The 4/03/13 NSA/HSP (health service plan) contained a check mark for " agitated at times " and did not contain a check mark for " aggressive. " HSP contained an intervention dated 4/09/13 " If exhibits increase in agitation certified/licensed staff to	S5026		

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S5026	Continued From page 7 administer PRN (as needed) RX (prescription). " The medical record (FCS, NSA, HSP, Nursing Notes) lacked a written plan for aggressive/assaultive behavior. The medical record failed to identify measures to prevent further physical contacts by #4 - By interview on 9/03/13 at 1:15pm, Operator stated "#4 " does have Sundowner's... sometimes aggressive towards staff, no aggression or interactions towards Residents." By interview on 9/03/13 at 2:00pm, RAC/LPN #B stated #4 gets verbally agitated, wants to leave... agitation towards Resident #2, grabbed by wrist maybe two weeks ago. LPN #B confirmed altercation not documented in the Nursing Notes or medical record. RAC/LPN #B and Facility RN #A provided staff communication notes of 8/14/13 that stated "#4 and #2 got into it about the table lamp. #4 also grabbed #2's wrist pretty hard. May look for bruising later." LPN #B and RN #A confirmed staff communication notes missing for period of 8/20/13 to 8/22/13. LPN #B and RN #A provided an Incident Report dated 8/21/13 (incident occurred on 8/20/13 according to Confidential interview and medication administration record documentation of Ativan). 1st Page Incident Report stated " #4 grabbed #2 ' s hand and twisted it ... [Active/Passive Range of motion] without complaint of pain. No obvious deformity or no limited [Range of Motion]. No discoloration. Ice applied by LPN #B, but refused, faxed report to physician 8/21/13 at 1700. " 2nd page of Incident Report with sub heading "	S5026		

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S5026	Continued From page 8	S5026		

Investigation " stated " Resident wanted TV off and the other Resident wanted it on ... " #2 wanted it on. #4 got mad towards #2 and twisted #2 ' s hand. I (CMA #F) sat #4 down then he/she got madder. " What was involved person attempting to do? " Protecting her/his TV from being turned off. " Why did this incident occur? " #4 did not want anyone to watch TV would not go into the other room. Would not listen to reason. " What was done immediately? " He/she was medicated (for anxiety agitation). " This page completed by CMA #F; LPN #B signed on 8/22/13 and added note at bottom " 8/22/13 spoke with #2 ' s family regarding incident no injury evident voiced concerns related to peer-resident. Discussed. "
3rd page of Incident Report with heading " Incident Witness Statement. " This form contained the following by CMA #F " Resident #4 was arguing with #2 when I came on duty - over TV several times he/she turned it off , resident #2 went in front of TV #4 got mad and twisted #2 ' s hand, I sat #4 down and he/she became more angry at me. " This page signed by CMA #F on 8/22/13.

By interview on 9/03/13 at 6:00pm, Operator and RAC/LPN #B confirmed knowledge of at least two incidents between resident #4 and resident #2 (8/14 and 8/20/13) and further confirmed the incidents were not documented in the residents records.

By confidential interview on 9/04/13, an individual stated " resident #4 did assault CMA #F and also assaulted CMA #G by hitting extremely hard in the back... CMA #G went home crying...resident #4 has done things to resident #2 a lot... there are communication notes missing that talked about resident #4 pushing resident #2 backwards into a

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S5026	Continued From page 9 chair besides grabbing and twisting arm... resident #2 has verbalized fear of resident #4.. . resident #4 invades resident #2's room... was found sleeping on #2's bed... I know RAC/LPN #B aware. " For resident #2, the operator failed to ensure that no resident was subjected to verbal, mental or physical abuse when Resident #2 subjected to repeated physical aggression and invasion of his/her room by resident #4. Resident #2 experienced pain from grabbing and twisting injuries and repeatedly verbalized fear for Resident #4.	S5026		
S5028 SS=F	26-42-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the home as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the	S5028		

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S5028	Continued From page 10 department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(f)(3) The census equalled five the sample included five Residents. Based on observations, interviews, and reviews of records, for three of five sample (#2, #3, and #4), the Operator failed to ensure: 1) Each allegation of abuse reported to the Department within 24 hours 2) An investigation started when the Operator received the allegations, to rule out the possibility of abuse 3) Immediate measures taken to prevent further potential abuse when #2 experienced physical pushing and twisting of left arm by #4 and invasion of his/her bedroom by resident #4 on multiple occasions and #3 experienced bruising to forehead, face, eye, and chin. Findings included: Resident #4 admitted to facility 4/03/13 with diagnoses of Dementia, Agitation, Psychosis, Parkinson's, Muscle spasms, Insomnia, and Status post pneumonia. The 4/03/13 FCS (functional capacity screen) assessed #4 in need of physical assistance with bathing, unable to perform medication and treatment management; with Falls/unsteadiness, Impaired cognition and	S5028		

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S5028	Continued From page 11 Impaired decision making. " The 4/03/13 NSA(negotiated service agreement)/HSP (health service plan) contained a check mark for " agitated at times " and did not contain a check mark for " aggressive. " HSP contained an intervention dated 4/09/13 " If exhibits increase in agitation certified/licensed staff to administer PRN (as needed) RX (prescription). " The medical record (FCS, NSA, HSP, Nursing Notes) lacked a written plan for aggressive/assaultive behavior. The medical record failed to identify measures to prevent further physical contacts by #4 - By interview on 9/03/13 at 1:15pm, Operator stated "#4 " does have Sundowner's... sometimes aggressive towards staff, no aggression or interactions towards Residents." By interview on 9/03/13 at 2:00pm, RAC (Resident assessment coordinator)/LPN #B stated #4 gets verbally agitated, wants to leave... agitation towards Resident #2, has grabbed by wrist... one time, maybe two weeks ago... not in the Nursing Notes or medical record... have incident report " On 9/03/13 at 6:10pm, Operator, RAC/LPN #B, and RN #A stated #4 did not assault any other Residents besides #2 but did physically pull buttons off staff shirt (CMA #F) and pushed CMA #F to floor injuring staff. RAC/LPN #B and Facility RN #A provided staff communication notes of 8/14/13 that stated "#4 and #2 got into it about the table lamp. #4 also grabbed #2's wrist pretty hard. May look for bruising later." LPN #B and RN #A confirmed staff communication notes missing for period of 8/20/13 to 8/22/13.	S5028		

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S5028	Continued From page 12 LPN #B and RN #A provided an Incident Report dated 8/21/13 (incident occurred on 8/20/13 according to Confidential interview and medication administration record documentation of Ativan). 1st Page Incident Report stated " #4 grabbed #2 ' s hand and twisted it ... [Active range of motion/Passive range of motion] without complaint of pain. No obvious deformity or no limited [Range of Motion] No discoloration. Ice applied by LPN #B, but refused, faxed report to physician 8/21/13 at 1700. " 2nd page of Incident Report with sub heading " Investigation " stated " Resident wanted TV off and the other Resident wanted it on ... " #2 wanted it on. #4 got mad towards #2 and twisted #2 ' s hand. I (CMA #F) sat #4 down then he/she got madder. " What was involved person attempting to do? " Protecting her/his TV from being turned off. " Why did this incident occur? " #4 did not want anyone to watch TV would not go into the other room. Would not listen to reason. " What was done immediately? " He/she was medicated (for anxiety agitation). " This page completed by CMA #F; LPN #B signed on 8/22/13 and added note at bottom " 8/22/13 spoke with #2 ' s family regarding incident no injury evident voiced concerns related to peer-resident. Discussed. " 3rd page of Incident Report with heading " Incident Witness Statement. " This form contained the following by CMA #F " Resident #4 was arguing with #2 when I came on duty - over TV several times he /she turned it off , resident #2 went in front of TV #4 got mad and twisted #2 ' s hand, I sat #4 down and he/she became more angry at me. " This page signed by CMA #F on 8/22/13. By interview on 9/03/13 at 3:34pm, RAC/LPN #B	S5028		

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S5028	Continued From page 13 and Facility RN #A confirmed staff communication notes and incident report not part of medical record... each stated I never "called in" or reported to Department or anything... each stated not aware of any facility policy and procedure for that. By interview on 9/03/13 at 6:00pm, Operator and RAC/LPN #B confirmed nothing documented in resident #2 ' s medical record for August 2013 ... with last Nursing Notes entry dated 7/08/13 ... each confirmed knowledge of at least two incidents (8/14 and 8/20/13) since then.. By confidential interview on 9/04/13, an individual stated " resident #4 did assault CMA #F and also assaulted CMA #G by hitting extremely hard in the back... CMA #G went home crying...resident #4 has done things to resident #2 a lot... there are communication notes missing that talked about resident #4 pushing resident #2 backwards into a chair besides grabbing and twisting arm... resident #2 has verbalized fear of resident #4... resident #4 invades resident #2's room... was found sleeping on #2's bed... I know RAC/LPN #B aware. " Resident #2 admitted to facility 10/01/10 with diagnoses of Cerebral atrophy, Cerebral vascular disease, Depression, Hypertension, Osteoarthritis, Dyslipidemia, Incontinence, Dysphagia, and Renal Insufficiency. The 02/11/13 FCS assessed #2 in need of physical assistance with bathing, dressing, transfers, mobility; unable to perform toileting, medication and treatment management; with Incontinence; Falls/unsteadiness; Short term memory, recall, and impaired decision making. The NSA stated	S5028		

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S5028	Continued From page 14 services to address all the identified needs listed above provided by facility staff. By confidential interview on 9/05/13 an individual stated I am aware that resident #4 started bothering resident #2 in March or April ... around tax time... #2 started sharing comments about #4 ... " pushed me in my room, pushed me back in chair ... will stand by my bed and stare at me " adding " that scares me " and " I pretend I am asleep " ... I know a family member told RAC/LPN #B to keep resident #4 away from resident #2.. on 8/14/13 #4 twisted #2's wrist... on 8/20/13 #4 pushed #2 by the TV, then went after CMA #F... I know another staff CMA #G also got socked in the back. By confidential interview on 9/05/13 another individual stated I know resident #4 hit or shoved resident #2... it got pretty bad, not too long ago. By interview on 9/04/13 Resident #2 displayed great sincerity and used facial expressions and arm gestures to convey a great deal of his/her recollection ... when asked " Do you feel safe? Resident #2 replied " a little, I don ' t know, not much " ... " He/she hit me and bopped the nurse " ... Observed gestures of #2 as he/she patted own forearm while describing altercation with resident #4 at the table lamp ... observed gestures as #2 patted and touched own wrist as described TV altercation with resident #4 ... observed resident #2 pat hip and knee, eyes wide, describing staff on floor " I was begging nurse please get up " (when staff intervened when Resident #4 grabbing resident #2 ' s wrists at the TV). Resident #2 also referred to a time when resident #4 pushed him/her back in chair	S5028		

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S5028	Continued From page 15 but added " I didn ' t fall " . Resident #2 stated " I pretend to be asleep when #4 comes into my room... #4 has hurt my arm and has hurt the nurses who work here " ... #2 again described #4's assault and injury of staff... " #4 has taken things from my room... I have to stay quiet as I can when he/she comes in my room, he/she sits in a chair by me... " ... #2 made multiple hand demonstrations of placing personal belongings in pocket and under pillow at night " to keep them safe " ... and occasionally grabbed walker stating " I keep it close by so my things are safe " (walker has storage bag hanging on front with belongings inside). For residents #2 and #4, the operator failed to report allegations of abuse to the department within 24 hours and failed implement immediate measures to prevent further potential abuse. Resident #3 admitted to facility 9/29/12 with diagnoses of Alzheimer's, Cerebral atrophy, Osteoporosis, Rheumatoid arthritis, Hypothyroidism, Constipation, Gastroesophageal reflux disease, and Constipation. The 02/11/13 FCS (functional capacity screen) assessed #1 in need of physical assistance with bathing, dressing, toileting, mobility, and eating; unable to perform medication and treatment management; Incontinent; Impaired cognition and communication; with Falls/unsteadiness, Socially inappropriate disruptive behavior, Wandering (in wheelchair), and Impaired decision making. The NSA includes services to address mobility (assist with ambulation and transfers PRN and upon first walking), behaviors (redirect Resident when behaviors present), wandering (redirect as needed - encourage activity participation), and impaired decisions (redirect as needed), all provided by facility staff.	S5028		

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S5028	Continued From page 16 Observations of this Resident: 9/03/13 in bed asleep at 1:25pm; loud random vocalizations when in wheelchair in living room and at dining table at 5:00 pm meal time. By confidential interview on 9/04/13, an individual stated " resident #3 with bruising of lower chin at one time like hand grabbed chin... another time, bruising of forehead and face, not sure what happened either time ... an incident report stated #3 hit forehead on table but Residents #2 and #4 stated #3 fell out of wheelchair onto floor and hit face " . By confidential interview on 9/04/13, another individual stated not sure of date, " resident #3 with bruising all over face and eyes... when asked what happened to #3 ... everybody kept saying nobody knows what happened, it's been investigated, we've let the right people know. " By interview on 9/04/13 at 1:30pm, RAC/LPN #B stated not aware of documentation available for any bruising incidents of #3's forehead, eyes, face, or chin. On 9/04/13 at 2:04pm observed Operator and LPN #B reviewing staff communication book in living room... RAC/LPN #B called CMA #E to living room and asked " Do you know anything about bruising for resident #3?... CMA #E responded " I gave you incident report " . LPN #B stated to Surveyor " oh yes, I remember, we re-enacted and determined when resident #3 gets meds, he/she turns head and connects with spoon causing bruise or discoloration of lip ". Surveyor confirmed lip not chin? Operator, RAC/LPN #B and CMA #E all confirmed aware of	S5028		

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S5028	Continued From page 17 lip bruising, re-enactment to determine cause, and no documentation in medical record or in staff communication notebook regarding chin bruising. When incident report, dated 6/18/13 referred to by CMA #E reviewed, documented bruising to upper forehead because #3 hit head on table when bending over to pick up dropped spoon and bumped head on table... This report lacked a description any bruising of lip, chin, face, or eyes. Nursing Notes lacked documentation of any bruising for #3 on any date, to chin, eyes, face, or forehead. Facility staff confirmed 6/18/13 incident report for forehead only documentation available for these alleged bruising injuries. By interview on 9/03/13 at 6:10pm, Operator provided multiple pages of definitions and procedures regarding the handling of abuse, neglect, exploitation allegations. Operator confirmed this facility name inserted into the provided policies and procedures that detailed the requirements for identifying, reporting, investigating thoroughly, and taking corrective actions. These facility policies and procedures specified any and all allegations to be reported to the Operator, and the Operator to investigate, maintain documentation, and initiate corrective action. For each allegation of abuse for residents #2, #3, and #4, the Operator failed to implement policies and procedures to investigate, report, take immediate measures to prevent further potential abuse and implement appropriate corrective action.	S5028		

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S5055 SS=D	26-42-101 (l) Survey Report l) Survey report and plan of correction. Each administrator or operator shall ensure that a copy of the most recent survey report and plan of correction is available in a common area to residents and any other individuals wishing to examine survey results. This REQUIREMENT is not met as evidenced by: KAR 26-42-101(l) The census equalled five the sample included four Residents, and focused reviews completed on one current Resident and three discharged Residents. Based on observations and interview, the Operator failed to ensure a copy of the most recent survey report available in a common area to anyone wishing to examine survey results. Findings included: - By observation of general living areas at time of entrance to facility on 9/03/13 at 12:45pm, last resurvey not visible. By observation no written posting of where to find last resurvey results. By interview on 9/03/13 at 12:45pm, Operator agrees the last resurvey not posted anywhere; Operator continued to look in records closet and through notebooks and documents on kitchen counter. Operator located the last resurvey in a notebook in the kitchen, stored with additional notebooks of policies and Resident care records. The Operator failed to ensure a copy of the most recent survey report available in a common area to anyone wishing to examine survey results.	S5055		

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S5095	Continued From page 19	S5095		
S5095 SS=D	26-42-201 (d) Functional Capacity Screen Accurate (d) Designated staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(d) The census equalled five the sample included five current Residents and three discharged Residents. Based on review of record and interview, for one of eight sampled (Resident #4), the Operator failed to ensure designated staff completed a FCS (functional capacity screen) that accurately reflected the Resident's functional status on the screening form. Findings included: - Review of record revealed resident #4 admitted to facility 4/03/13 with diagnoses of Dementia, Parkinson's, Agitation, Psychosis, Insomnia, Muscle spasms, and Status post pneumonia. The 4/3/13 FCS assessed resident #4 in need of physical assistance with bathing, unable to perform medication and treatment management, and in need of supervision with dressing and toileting. The 4/3/13 NSA (negotiated service agreement) stated staff physically assisted resident #4 with toileting when occasionally incontinent. 4/03/13 HSP (health service plan) included "agitated at times... if increase in agitation	S5095		

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S5095	Continued From page 20 administer medication, and included elopement risk and exit seeking behavior. The FCS failed to reflect accurately #4's need of physical assistance with toileting at times. By interview on 9/03/13 at 2:37pm Facility RN (registered nurse) #A stated " staff wipe him/her if necessary, if not clean...agreed FCS did not reflect physical assistance with toileting. " For resident #4, the Operator failed to ensure the resident ' s functional capacity was accurately reflected on the resident ' s FCS by designated staff.	S5095		
S5105 SS=D	26-42-202 (a) Negotiated Service Agreement a) The administrator or operator of each home plus shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service.	S5105		

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S5105	Continued From page 21 This REQUIREMENT is not met as evidenced by: KAR 26-42-202(a) The census equalled five, the sample included four Residents. Based on review of record and interview, for one of four sampled (#1), the Operator failed to ensure the development of a written negotiated service agreement (NSA). Findings included: - Review of record revealed #1 admitted to facility 7/26/12 with diagnoses of Alzheimer's, Diabetes, Cerebral artery disease, Hyperlipidemia, Hypertension, Hypothyroidism, Dementia, Vertigo, Hearing loss, and Gastroesophageal reflux disease. The medical record contained an 02/11/13 FCS (functional capacity screen) that assessed #1 in need of physical assistance (2) with bathing, dressing, toileting; unable to perform (3) medication and treatment management; Incontinent (4); Cognitive impairment (4) related to short/long term memory, memory recall, decision making; Impaired communication (2-2); Falls/unsteadiness; Impaired vision and hearing; and with Socially inappropriate disruptive behavior and Impaired decision making. The medical record lacked an NSA to address these identified needs. On 9/04/13 at 5:40pm Operator confirmed no NSA available for #1. The Operator failed to ensure the development of a written NSA for #1.	S5105		

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S5155	Continued From page 22	S5155		
S5155 SS=E	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (a) The census equalled five the sample included five current Residents. Based on observations, interviews, and reviews of records, for one of five (#4), the Operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of Resident #4 who repeatedly physically attacked Resident #2 and invaded her room. Findings included: - Resident #4 admitted to facility 4/03/13 with diagnoses of Dementia, Agitation, Psychosis, Parkinson's, Muscle spasms, Insomnia, and Status post pneumonia. The 4/03/13 FCS (Functional Capacity Screen) assessed #4 in need of physical assistance with bathing, unable to perform medication and treatment management; with Falls/unsteadiness, Impaired cognition and Impaired decision making. The 4/03/13 NSA stated services to address bathing (physically assist with shower twice weekly),	S5155		

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S5155	Continued From page 23 medication management (Certified/Licensed staff provide medication management), incontinence (cue every two hours while awake wears pull-ups at night), provided by facility staff. " The HSP (health care plan) stated " CMA ' s will administer all medications as ordered by client ' s physician if client unable to manage own medications, " " Every two hour toilet cuing while awake, wears pull-ups at night, " " Encourage to keep all bath days, one assist with shower, " The HSP (health care plan) contained a check mark for " agitated at times " and did not contain a check mark for " aggressive. " HSP contained an intervention dated 4/09/13 " If exhibits increase in agitation certified/licensed staff to administer PRN (as needed) RX (prescription). " The medical record (FCS, NSA, HSP, Nursing Notes) lacked a written plan for aggressive/assaultive behavior. The medical record failed to identify measures to prevent further physical contacts by #4. Review of MAR revealed the following: April 2013: PRN (as needed) Seroquel(for agitation) given on 10:45 a.m.4/4/13, 1 p.m. 4/9/13, 3 p.m. 4/10/13; 9 1.m. 4/11/13, 9 a.m. 4/12/13, 2 p.m. 4/15/13, 7 a.m. 4/17/13, 9 a.m. 4/25/13 and 7 a.m. 4/30/13; Routine Seroquel order changed from 12.5 mg (milligrams) daily to 12.5 mg three times a day on 4/16/13 May 2013: PRN Seroquel given no time listed 5/17/13; 7:43 a.m. 5/25/13; 8 a.m. 5/26/13 June 2013: PRN Seroquel given 10 p.m. 6/5/13, 10 p.m. 6/6/13; 9:45 p.m. 6/8/13; 8:05 p.m. 6/9/13; 8:40 a.m. 6/17/13; 6:45 p.m. 6/18/13; Routine Seroquel order changed from 12.5 mg three times a day to 25 mg three times a day on 6/20/13 August 2013PRN Ativan (for agitation) given at 12 p.m. and 6 p.m. on 8/20/13; 2 p.m. 8/22/13 and 9 p.m. 8/27/13.	S5155		

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S5155	Continued From page 24 Review of medical care provider notes of 6/19/13 visit for " behaviors and depression " includes " staff states he/she is getting combative in the afternoon; resident reported he/she is angry at family; medication changes to address dementia and behaviors. Review of Nursing Notes: 4/10/13 - 0900 - " ...occasional agitation/anxiety. Spoke with family about asking for increase in Seroquel which is OK with family ... " 4/11/13 - 1300 - " ...staff see increased restlessness late morning to mid afternoon ... " 4/12/13 - 1500 - " no exit seeking behaviors ... wanders about the home ... takes meds well ... " 4/23/13 - 0730 - " refused to allow tech to draw ordered labs ... Dr. notified ... " 7/01/13 - " no exit behaviors is pleasant to staff and other residents, wanders, will adjust with verbal prompt ... " Record lacked documentation of agitated, aggressive behaviors and lacked documentation notification of the nurse for PRN Seroquel. By interview on 9/03/13 at 1:15pm, Operator stated "#4 " does have Sundowner's... sometimes aggressive towards staff, no aggression or interactions towards Residents." By interview on 9/03/13 at 2:00pm, RAC (Resident assessment coordinator)/LPN #B stated #4 gets verbally agitated, wants to leave... agitation towards Resident #2, grabbed by wrist about two weeks ago; confirmed incident not in the Nursing Notes or medical record. " RAC/LPN #B and Facility RN #A provided staff	S5155		

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S5155	Continued From page 25	S5155		

communication notes of 8/14/13 that stated "#4 and #2 got into it about the table lamp. #4 also grabbed #2's wrist pretty hard. May look for bruising later." LPN #B and RN #A confirmed staff communication notes missing for period of 8/20/13 to 8/22/13.

LPN #B and RN #A provided an Incident Report dated 8/21/13 (incident occurred on 8/20/13 according to Confidential interview and MAR documentation of Ativan). 1st Page Incident Report stated " #4 grabbed #2 ' s hand and twisted it ... [Active/Passive range of motion] without complaint of pain. No obvious deformity or no limited [range of motion]. No discoloration. Ice applied by LPN #B, but refused, faxed report to physician 8/21/13 at 1700. "
2nd page of Incident Report with sub heading " Investigation " stated " Resident wanted TV off and the other Resident wanted it on ... " #2 wanted it on. #4 got mad towards #2 and twisted #2 ' s hand. I (CMA #F) sat #4 down then he/she got madder. " What was involved person attempting to do? " Protecting her/his TV from being turned off. " Why did this incident occur? " #4 did not want anyone to watch TV would not go into the other room. Would not listen to reason. " What was done immediately? " He/she was medicated (for anxiety agitation). " This page completed by CMA #F; LPN #B signed on 8/22/13 and added note at bottom " 8/22/13 spoke with #2 ' s family regarding incident no injury evident voiced concerns related to peer-resident. Discussed. " 3rd page of Incident Report with heading " Incident Witness Statement. " This form contained the following by CMA #F " Resident #4 was arguing with #2 when I came on duty - over TV several times he/she turned it off , resident #2 went in front of TV #4 got mad and twisted #2 ' s hand, I sat #4 down and he/she

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S5155	Continued From page 26 became more angry at me. " This page signed by CMA #F on 8/22/13. By interview on 9/03/13 at 6:00pm, Operator and RAC/LPN #B confirmed nothing documented in resident #2 ' s medical record for August 2013 ... with last Nursing Notes entry dated 7/08/13 ... each confirmed knowledge of at least two incidents (8/14 and 8/20/13) since then and further confirmed incidents not documented in residents records. By confidential interview on 9/04/13, an individual stated " resident #4 did assault CMA #F and also assaulted CMA #G by hitting extremely hard in the back... CMA #G went home crying...resident #4 has done things to resident #2 a lot... there are communication notes missing that talked about resident #4 pushing resident #2 backwards into a chair besides grabbing and twisting arm... resident #2 has verbalized fear of resident #4... resident #4 invades resident #2's room... was found sleeping on #2's bed... I know RAC/LPN #B aware. " On 9/03/13 from 1:02pm to 1:58pm, #4 sleeping soundly in living room recliner with chin to chest ... CMA #E keeping Residents in living room company until evening meal time ... #4 entered kitchen at intervals, smiled and greeted staff and visitors, then returned to living room area. On 9/03/13 at 4:55pm RN #A stated the CMA calls the nurse regarding PRN meds ... I tell CMA try warm towel and other interventions before a pill - if not effective give pill " ... RN #A confirmed these are verbal directions and not a written plan for resident #4.	S5155		

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S5155	Continued From page 27 Resident #2 - Admitted to facility 10/01/10 with diagnoses of Cerebral atrophy, Cerebral vascular disease, Depression, Hypertension, Osteoarthritis, Dyslipidemia, Incontinence, Dysphagia, and Renal Insufficiency. The 02/11/13 FCS assessed #2 in need of physical assistance with bathing, dressing, transfers, mobility; unable to perform toileting, medication and treatment management; with Incontinence; Falls/unsteadiness; Short term memory, recall, and impaired decision making. The NSA stated services to address all the identified needs listed above provided by facility staff. By confidential interview on 9/05/13 an individual stated I am aware that resident #4 started bothering resident #2 in March or April ... around tax time... #2 started sharing comments about #4 ... " pushed me in my room, pushed me back in chair ... will stand by my bed and stare at me " adding " that scares me " and " I pretend I am asleep " ... I know a family member told RAC/LPN #B to keep resident #4 away from resident #... on 8/14/13 #4 twisted #2's wrist... on 8/20/13 #4 pushed #2 by the TV, then went after CMA #F... I know another staff CMA #G also got socked in the back. By confidential interview on 9/05/13 another individual stated I know resident #4 hit or shoved resident #2... it got pretty bad, not too long ago... #4 got physical with two employees and ripped an employee's shirt. By interview on 9/04/13 Resident #2 displayed great sincerity and used facial expressions and arm gestures to convey a great deal of his/her recollection ... when asked " Do you feel safe?	S5155		

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S5155	Continued From page 28 Resident #2 replied " a little, I don ' t know, not much " ... " He/she hit me and bopped the nurse " ... Observed gestures of #2 as he/she patted own forearm while describing altercation with resident #4 at the table lamp ... observed gestures as #2 patted and touched own wrist as described TV altercation with resident #4 ... observed resident #2 pat hip and knee, eyes wide, describing staff on floor " I was begging nurse please get up " ... when staff intervened when Resident #4 grabbing resident #2 ' s wrists at the TV and Resident #4 became angry, tore staff clothing and pushed staff to staff to floor . Resident #2 also referred to a time when resident #4 pushed him/her back in chair but added " I didn ' t fall " . Resident #2 stated " I pretend to be asleep when #4 comes into my room... #4 has hurt my arm and has hurt the nurses who work here " ... #2 again described #4's assault and injury of staff... " #4 has taken things from my room... I have to stay quiet as I can when he/she comes in my room, he/she sits in a chair by me... " ... #2 made multiple hand demonstrations of placing personal belongings in pocket and under pillow at night " to keep them safe " ... and occasionally grabbed walker stating " I keep it close by so my things are safe " (walker has storage bag hanging on front with belongings inside). For Resident #4, the operator failed to ensure the licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of Resident #4 who exhibited aggressive, agitated behaviors repeatedly since admission in April 2013.	S5155		
S5171 SS=E	26-42-204 (i) Health Care Services Standards of Practice	S5171		

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S5171	Continued From page 29 (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 The census equalled five the sample included four Residents. Based on reviews of records and interviews, for two of four sampled (#1, and #4), the Operator failed to ensure all health care services provided to Residents by qualified staff in accordance with acceptable standards of practice. Findings included: - Review of record revealed #1 admitted to facility 7/26/12 with diagnoses of Alzheimer's, Diabetes, Cerebral artery disease, Hyperlipidemia, Hypertension, Hypothyroidism, Dementia, Vertigo, Hearing loss, and Gastroesophageal reflux disease. The 02/11/13 FCS (functional capacity screen) assessed #1 in need of physical assistance with bathing and unable to perform medication and treatment management. The medical record lacked an NSA (negotiated service agreement). 1) The HSP (health care plan) documented #1 to have "Total assistance with shower." Resident Log book recorded showers to be given on Mondays and Thursdays Showers given 8/19/13 and 8/22/13; no showers documented 8/12/13 to 8/18/13; no showers documented 8/23/13 to 9/04/13 2) The MAR (medication administration record)	S5171		

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S5171	Continued From page 30	S5171		

contained medical care provider orders for:
Accu-check fasting and 4pm once weekly and blood pressure weekly.
The MAR's documented: no blood pressure on 3/14/13,
The MAR's documented: 3/14/13; 8/08/13, 8/15/13, 8/22/13, and 8/29/13

3) The MAR contained medical care provider order for:
Turn hearing aide on and place in ear at 7am, remove, turn off and put away 7pm
The MAR's for March, April, May, June, July, August 2013 - documented "hearing aide not working... broken/broke... battery not available... battery dead... the MAR of August contained large "X's" through the dates of 8/17/13 to 8/31/13... no order to "discontinue" located.

On 9/04/13 at 5:40pm, RAC(Resident Assessment Coordinator)/LPN (Licensed practical nurse)#B confirmed baths, accu-checks, hearing aide assistance on the MAR's signed by medical care provider as orders... LPN #B confirmed documentation available stated these health care services not provided according to orders and according to standards of practice.

The Operator failed to ensure all health care services provided to #1 by qualified staff in accordance with acceptable standards of practice.

- Review of record revealed #4 admitted to facility 4/03/13 with diagnoses of Dementia, Agitation, Psychosis, Parkinson's, Muscle spasms, Insomnia, and Status post pneumonia. The 4/03/13 FCS assessed #4 in need of physical assistance with bathing, unable to perform

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S5171	Continued From page 31 medication and treatment management. 1) The 4/03/13 NSA and HSP stated bathing assistance provided by facility staff twice weekly. Bathing work sheets documented #4 received no bath/shower 8/19/13 to 9/04/13. 2) The MAR's contained medical care provider orders for weight weekly and blood pressure weekly. The MAR's documented no weekly weight completed in June and July 2013, documented weight "refused" 8/07/13 and 8/14/13 The MAR's documented no weekly blood pressure July 2013. On 9/04/13 at 5:40pm, RAC/LPN #B confirmed baths/showers not given according to NSA and HSP... confirmed medical care provider orders for weights and blood pressure checks on the MAR not documented as completed in accordance with standards of practice. The Operator failed to ensure all health care services provided to #4 by qualified staff in accordance with acceptable standards of practice. For Residents #1, and #4, the Operator failed to ensure all health care services provided to Residents by qualified staff in accordance with acceptable standards of practice.	S5171		
S5186 SS=F	26-42-206 (d) Dietary Services Menus (d) The menus shall be planned in advance and in accordance with the dietary guidelines adopted by reference in K.A.R. 26-39-105.	S5186		

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S5186	Continued From page 32 This REQUIREMENT is not met as evidenced by: KAR 26-42-206(d) The census equalled five, the sample included five current Residents. Facility identified all five Residents as receiving meal service. Based on observation, interview, and reviews of record, for all Residents of facility (#1, #2, #3, #4, and #9), the Operator failed to ensure all menus planned in accordance with the dietary guidelines adopted by reference in KAR 26-39-105. Findings included: - Confidential interviews revealed multiple concerns and complaints about the food served in the facility. Observations on 9/03/13 at 1:39 pm revealed a seven day menu posted on the kitchen refrigerator. This menu failed to meet the minimum recommended dietary requirements: (B) Breakfast; (L) Lunch; (D) Dinner Fruits recommended 1 1/2 cups daily: 8/31/13 - 1/2 banana (B), 1/2 cup fruit cocktail (L) 9/01/13 - "fruit serve one" (B), with no other fruits in planned menu 9/02/13 - fruit cocktail 1/2 cup (L), peaches 1/2 cup (D) 9/03/13 - 1/2 banana (B), pears 1/2 cup (L) 9/04/13 - fruit cocktail 1/2 cup (L), pears 1/2 cup (D) 9/05/12 - 1/2 banana (B), jello with fruit serve 1/2 cup (D) 9/06/13 no fruit listed in posted menu Protein foods recommended 5 oz (ounces) daily:	S5186		

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S5186	Continued From page 33 8/31/13 - bacon 2 pieces (B), roast beef with roasted vegetables serve 3 oz (L), tuna salad serve 1/4 cup (D) 9/01/13 - yogurt serve one (B), pizza serve 1 piece (L), cooks choice (leftovers) (D) 9/02/13 - egg serve one, bacon 2 pieces (B), smothered pork chop 3 oz (L), grilled cheese sandwich (D) 9/03/13 - sausage 2 pieces (B), Progresso hearty Veg Soup over egg noodles serve 1 cup (L), Cooks choice (leftovers) 9/04/13 - yogurt serve 1 (B), meatloaf serve 1 cup (L), Hamburger Helper serve 1 cup (D) 9/05/13 - sausage 2 pieces (B), chicken nuggets serve 4 (L), meatloaf sandwich serve 1 (D) 9/06/13 - egg serve 1, bacon 2 pieces (B), fish sticks 4 pieces (L), ham and cheese sandwich 1 (D) Vegetables recommended 2 to 2 1/2 cups daily (incorporating dark green vegetables, red and orange vegetables, beans and peas, and starchy vegetables: 8/31/13 - roast beef with roasted veggies serve 3 oz (L), Normandy vegetable blend 1 cup (D) 9/01/13 - mixed veggies serve 1/2 cup (L), cooks choice (leftovers) (D) 9/02/13 - green beans 1/2 cup (L), tomato soup 1/2 cup (D) 9/03/13 - Progresso Hearty Veg soup over egg noodles serve 1 cup (L), cook's choice (leftovers) (D) 9/04/13 - green beans 1/2 cup mashed potatoes 1/2 cup (L), Normandy veg 1/2 cup (D) 9/05/13 - corn 1/2 cup (L), mixed veggies 1/2 cup (D) 9/06/13 - french fries 3 oz, veggie of choice 1/2 cup (L) Dairy recommended at 3 cups per day:	S5186		

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S5186	Continued From page 34 8/31/13 no dairy products scheduled 9/01/13 - yogurt serve 1 (B) 9/02/13 - grilled cheese sandwich 1, tomato soup 1/2 cup (D) 9/03/13 no dairy products scheduled 9/04/13 - yogurt serve 1 (B) 9/05/13 - macaroni and cheese 1/2 cup (L) 9/06/13 - ham and cheese sandwich 1, cottage cheese 1/2 cup (D) "The menu contained a note at the bottom: (B) Drink Choice Milk or Coffee Offer a Yogurt cup at every breakfast (L) and (D) Drink of Choice." Grains recommended at 5 to 6 oz daily: 8/31/13 - oatmeal 1/2 cup, toast 1 slice (B), 1 slice bread (L), tuna salad 1/4 cup served as a sandwich or by itself 9/01/13 - 1 muffin (B), pizza 1 slice (L), cook's choice (leftovers) (D) 9/02/13 - toast 1 slice (B), bread 1 slice (L), grilled cheese sandwich 1 (D) 9/03/13 - pancake 1 (B), Progresso Veg soup over egg noodles 1 cup (L), cook's choice (leftovers)(D) 9/04/13 - cold cereal 1/2 cup, toast 1 slice (B), Hamburger Helper 1 cup (D) 9/05/13 - oatmeal 1/2 cup, toast 1 slice (B), macaroni and cheese 1/2 cup (L), 1 slice bread meatloaf sandwich (D) 9/06/13 - 1 slice toast (B), ham and cheese sandwich (D) Observation of noon meal on 9/03/13 with follow up review of meal ingredients revealed: Two cans of Progresso Soup used for five Residents; According to label each can include two servings with a total of 16 grams of protein per can for a total of 4.5 ounces of protein (7 grams = one ounce of protein) which resulted in less than 1	S5186		

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S5186	Continued From page 35 ounce of protein per resident The "seasoned broccoli serve 1/2 cup" listed on the menu was crossed out and not replaced. The meal consisted of four servings of vegetable soup for five Residents poured over egg noodles, and 1/2 cup pears. Observation of the evening meal on 9/03/13 (Cook's choice, Leftovers) revealed Tomato Soup (two cans), Grilled cheese sandwich, Coffee, Juice, Tea, Water. Previous three weeks of menus repeated the same patterns listed above, with the planned fruit items on menus as follows: With no more than 1 cup fruit per day, no fruit on 1 day per week and ½ banana 3 times a week for breakfast as the only fresh fruit. By interview on 9/03/13 at 1:39pm, when Operator asked if any fresh fruit served, stated " we always have bananas available. " Observed two brown bananas on top of the built in oven. Operator confirmed no other fresh fruit here at this time. By Confidential interview an individual stated " sometimes repeat dinner served two nights in a row because nothing else available... (9/02/13 and 9/03/13 grilled cheese and tomato soup).. . family and staff bring in a lot of food... some employees have brought in cases of food because tired of seeing the same old garbage served to Residents over and over... no fresh fruits, no juices... I know one employee wrote roast, potatoes, carrots, cabbage on grocery list because some Residents requested that as a meal... the Operator reprimanded the employee, stated we have a menu to follow. "	S5186		

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S5186	Continued From page 36 By Confidential interview another individual stated a lot of the times employees brought in food... owners would tell staff to make do with what you have... lot of peanut butter and jelly sandwiches... By Confidential interview another individual stated they have Hamburger Helper three times a week, no fruit, twice in one week leftovers... family members and staff bring in a lot of food every week, fruits, vegetables, chicken, desserts. By Confidential interview another individual stated concerns included food issue, " never enough food for Residents... example (B) menu stated cook 1 egg, two pieces of bacon, 1 piece toast... the bacon strips are cut in half so really they are getting one piece of bacon... toddlers can eat more than that for breakfast... one time a chicken pasta dish posted on menu, no chicken in facility had to just serve the pasta... when Operator or RAC/LPN #B notified of things not available, just tell staff to make it "cook's choice" or use leftovers, whatever they need to do... four fish sticks and a couple fries and a peach slice considered a meal... serve ham and cheese sandwich two to three times per week. " By Confidential interviews Residents confirmed concerns about food by others, using the words "terrible", "funny", "ugly" "OK", "some can cook and some can't", "sometimes I go to bed hungry"... Resident interviews confirmed family and staff bring large amounts of food in to facility due to poor menu and things on menu not always available to prepare. By interview on 9/04/13 at 1:40pm Operator stated " we elicit input for menus by talking to staff and Residents... substitutions are made	S5186		

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S5186	Continued From page 37 through me... occasionally we may be out of something and have to put other things on the meal... I do the menus per the "Plate Method"... no written satisfaction survey, that has been done verbally (facility policy stated Director will periodically conduct a Resident satisfaction survey). " By interview on 9/04/13 at 6:15pm, Operator stated not aware of the Dietary Requirements referenced in the regulations. The Operator failed to ensure all menus planned in accordance with the dietary guidelines adopted by reference in KAR 26-39-105.	S5186		
S5250 SS=D	26-42-105 (f) (1 - 10) Resident Records Content (f) Each resident record shall contain at least the following: (1) The resident's name; (2) the dates of admission and discharge; (3) the admission agreement and any amendments; (4) the functional capacity screenings; (5) the health care service plan, if applicable; (6) the negotiated service agreement and any revisions; (7) the name, address, and telephone number of the physician and the dentist to be notified in an emergency; (8) the name, address, and telephone number of the legal representative or the individual of the resident's choice to be notified in the event of a significant change in condition; (9) the name, address, and telephone number of the case manager, if applicable; (10) records of medications, biologicals, and	S5250		

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S5250	Continued From page 38 treatments administered and each medical care provider ' s order if the facility is managing the resident's medications and medical treatments; and This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(6) The census equalled five the sample included four Residents, and focused reviews completed on one current Resident and three discharged Residents. Based on review of record and interview, for one of four sampled (#1), the Operator failed to ensure the medical record contained a written negotiated service agreement (NSA). Findings included: - Review of record revealed #1 admitted to facility 7/26/12 with diagnoses of Alzheimer's, Diabetes, Cerebral artery disease, Hyperlipidemia, Hypertension, Hypothyroidism, Dementia, Vertigo, Hearing loss, and Gastroesophageal reflux disease. The medical record contained an 02/11/13 FCS (functional capacity screen) that assessed #1 in need of physical assistance (2) with bathing, dressing, toileting; unable to perform (3) medication and treatment management; Incontinent (4); Cognitive impairment (4) related to short/long term memory, recall, decision making; Impaired communication (2-2); Falls/unsteadiness; Impaired vision and hearing; and with Socially inappropriate disruptive behavior and Impaired decision making. The medical record lacked an NSA(negotiated service agreement) to address these identified needs.	S5250		

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S5250	Continued From page 39 On 9/04/13 at 5:40pm Operator and RAC (Resident assessment coordinator) LPN #B confirmed no NSA available for #1. For Resident #1, the Operator failed to ensure the medical record contained a written NSA for #1.	S5250		
S5251 SS=F	26-42-105 (f) (11) Resident Records Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-105(f)(11) The census equalled five the sample included four Residents. Based on interviews, observation, and reviews of records, for three of four Sampled Residents (#2, #3, and #4), the Operator failed to ensure the medical record contained documentation of all incidents, symptoms, and other indications of illness or injury including date, time, action taken, and results of the action. Findings included: - Review of record revealed #2 admitted to facility 10/01/10 with diagnoses of Cerebral atrophy, Cerebral vascular disease, Depression,	S5251		

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S5251	Continued From page 40 Hypertension, Osteoarthritis, Dyslipidemia, Incontinence, Dysphagia, and Renal Insufficiency. The 02/11/13 FCS (functional capacity screen) assessed #2 in need of physical assistance with bathing, dressing, transfers, mobility; unable to perform toileting, medication and treatment management; with Incontinence; Falls/unsteadiness; Short term memory, recall, and impaired decision making. The NSA (negotiated service agreement) stated services to assist Resident with activities of daily living, medication management, re-orientation and cognitive cuing, and fall prevention provided by facility staff. Confidential interviews, staff interviews, and notes in a facility communication notebook described physical altercations between #2 and #4, and #2's ongoing uncomfortable feelings towards #4. By interviews, incidents occurred as early as April 2013, but communication notebook not available for that time period... notebook available for portions of August and September. One incident report provided, dated 8/21/13 described physical interactions between Resident #2 and resident #4. Review of the medical record documentation from 02/11/13 to 9/03/13 lacked documentation of any verbal or physical altercations between #2 and any other Resident. Record lacked documentation of any actions taken, or the results of such actions. On 9/03/13 at 5:04pm and 5:10pm, RAC(Resident Assessment Coordinator)/LPN (Licensed practical nurse)#B and RN #A confirmed physical altercations occurred on 8/14/13 and 8/20/13... confirmed no medical record documentation available with last Nursing Note entry for #2 dated 7/08/13.	S5251		

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S5251	Continued From page 41 By interview on 9/03/13 at 6:00pm, Operator and RAC/LPN #B confirmed nothing documented in August 2013 for #2... last entry dated 7/08/13, and each confirmed at least two incidents we know of have occurred since then... confirmed no documentation policies and procedures available. The Operator failed to ensure the medical record for #2 contained documentation of all incidents, actions taken, and results of the actions. - Review of record revealed #3 admitted to facility 9/29/12 with diagnoses of Alzheimer's, Cerebral atrophy, Osteoporosis, Rheumatoid arthritis, Hypothyroidism, Constipation, Gastroesophageal reflux disease, and Constipation. The 02/11/13 FCS assessed #3 in need of physical assistance with bathing, dressing, toileting, mobility, and eating; unable to perform medication and treatment management; Incontinent; Impaired cognition and communication; with Falls/unsteadiness, Socially inappropriate disruptive behavior, Wandering (in wheelchair), and Impaired decision making. The NSA stated services to address activities of daily living, medication/treatment management, re-orientation due to cognitive impairment, and fall prevention all provided by facility staff. Observations of #3: 9/03/13 in bed asleep at 1:25pm; loud random vocalizations when in wheelchair in living room and at dining table near 5:00pm meal time. Confidential interviews reported two instances of Resident bruising. Review of the medical record documentation from 02/11/13 to 9/03/13 lacked mention of bruising or other symptoms of injury for #3.	S5251		

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S5251	Continued From page 42 By interview on 9/04/13 at 1:30pm, RAC/LPN #B stated no documentation available for any bruising incidents of #3's forehead, eyes, face, or chin. On 9/04/13 at 2:04pm Operator and LPN #B reviewing staff communication book stated " I do remember bruising... we re-enacted and determined when #3 gets meds, #3 turns head and connects with spoon causing bruise or discoloration of lip. " On 9/04/13 at 2:04pm, Operator, RAC/LPN #B, and CMA (certified medication aide) #E confirmed no documentation for chin bruising... no medical record documentation for any symptoms of injury, actions taken, or response to actions. The Operator failed to ensure the medical record of Resident #3 contained documentation of all incidents, injuries, date, time, actions taken, and response to actions. - Review of record revealed #4 admitted 4/03/13 with diagnoses of Dementia, Agitation, Psychosis, Parkinson's, Muscle spasms, Insomnia, and Status post pneumonia. The 4/03/13 FCS assessed Resident #4 in need of physical assistance with bathing, unable to perform medication and treatment management; with Falls/unsteadiness, Impaired cognition and Impaired decision making. The 4/03/13 NSA stated services to address bathing, medication management, incontinence, and impaired decision making provided by facility staff.	S5251		

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S5251	Continued From page 43 By review: 1) Physician visit of 6/19/13 documented medication increase and staff reported combativeness; the medical record lacked documentation of symptoms, signs of illness, actions taken, response to actions 2) MAR's (Medication administration record) contained entries all medications held due to nausea and vomiting (8/30/13); medication refusals (5/15/13, 5/25/13, 5/26/13, 5/28/13, 5/29/13, 6/11/13, 6/19/13, 7/12/13,) discontinuation of hydroxyzine on 6/13/13; administration of PRN (as needed) medications for agitation on (4/09/13, 4/10/13, 4/11/13, 4/12/13, 4/15/13, 4/17/13, 4/25/13, 4/30/13, 5/25/13, 5/17/13, 5/26/13) the medical record lacked documentation of contact with licensed nurse, symptoms, signs of illness, actions taken, and response to actions. By interview on 9/03/13 at 1:15pm, Operator stated "Resident #4 admitted in April/May... does have Sundowner's... sometimes aggressive towards staff... no aggression or interactions towards Residents." By review, the described aggression and Sundowner's not documented in the medical record. By interview on 9/03/13 at 2:00pm, RAC/LPN #B stated #4 gets verbally agitated, wants to leave... agitation with Resident #2, has grabbed #2 by wrist... maybe two weeks ago... not in the Nursing Notes or medical record. RAC/LPN #B and Facility RN #A provided facility communication notes of 8/14/13 that documented physical altercation between #4 and #2, and 8/21/13 incident report that documented	S5251		

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S5251	Continued From page 44 altercation between #2 and #4. By interview on 9/03/13 at 3:34pm, RAC/LPN #B and Facility RN #A confirmed staff communication notes and incident report not part of medical record... no other documentation available. The Operator failed to ensure the medical record for #4 contained documentation of all incidents, symptoms, actions taken and results of actions.	S5251		
S5300 SS=F	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The census equalled five the sample included	S5300		

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S5300	Continued From page 45 four Residents, and focused reviews completed on one current Resident and three discharged Residents. The facility identified all Residents as receiving medication management. Based on interviews and reviews of records, for three of four Sampled Residents with medication management (#1, #3, and #4), and four focused review Residents with medication management (#7, #8, #9 and #6), the Operator failed to ensure all medications and biologicals administered to each Resident in accordance with a medical care provider's written order and in accordance with professional standards of practice. Findings included: - Review of records revealed #7 admitted to facility 4/29/13 with diagnoses of Hypertension, Dementia, Hypothyroidism, Pain, Insomnia, and Allergies. The 4/29/13 FCS (functional capacity screen) assessed #7 unable to perform medication and treatment management. The 4/29/13 NSA (negotiated service agreement) stated facility staff to provide medication management. Physician orders at time of admission directed Atenolol, Calcim with Vitamin D, Aricept, Allegra, Levothyroxine, Meloxicam, Niacin, Premarin, Thera tab multivitamin, Fluticasone, Tramadol, Aspirin, Ambien, and Tylenol be administered to #7. The orders directed scheduled times at 0800, 1000, 1700, 2000, and PRN (as needed). Review of the April 2013 MAR's (medication administration records) revealed no documented doses of any medications on 4/29/13 and 4/30/13. On 9/18/13 at 3:37pm, RAC/LPN #B confirmed no medications documented for April 2013... It's	S5300		

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S5300	Continued From page 46 like he/she never existed." Medical record contained prescriptions for eye medications (Muro 128 Ophthalmic Solution and Systane Ultra Ophthalmic Solution) dated 5/29/13. Each presciption stated medications to be administered to both eyes every day. These medications were not included on the May 2013 MAR. On 9/18/13 at 5:05pm, RN #A confirmed he/she took #7 to eye doctor appointment... it was on a "Thursday or a Friday" (23rd or 24th). RN #A stated the receptionist (at eye doctor office) commented it's too late to fax the orders tonight... so #A and #7 left the office and returned to facility. RN #A stated he/she remembered the eye doctor told #7 his/her eyes had deteriorated and needed medications... RN #A and RAC/LPN #B stated nothing documented in the medical record about eye appointment, no documentation related to a delay in obtaining prescriptions when RN #A aware of need for medications. RN #A and RAC/LPN # B stated not able to remember why contact not made with eye doctor for faxes on Monday 5/27/13 instead of 5/29/13 (day #7 discharged). The Operator failed to ensure all medications and bioligicals for #7 administered in accordance with medical care provider written orders and in accordance with professional standards of practice. - Review of records revealed #8 admitted to facility 4/29/13 with diagnoses of Seizures, Hypertension, Constipation, Macrolytic anemia, Pain, Insomnia, and Poor Appetite. The 4/29/13 FCS (functional capacity screen) assessed #8	S5300		

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S5300	Continued From page 47 unable to perform medication and treatment management. The 4/29/13 NSA (negotiated service agreement) stated facility staff to provide medication management. Physician orders at time of admission directed Keppra, Lisinopril, Aspirin, Docusae, Ferrous Sulfate, Gabapentin, Megestrol, Metoprolol, Vitamin B12, Hydrocodone, Lidoderm, Melatonin, and Milk of Magnesia be administered to #8 at scheduled times of 0800, 1000, 1200, 1700, 2000, and PRN (as needed). Review of the April 2013 MAR's (medication administration records) revealed no documented doses of any medications on 4/29/13 and 4/30/13. On 9/18/13 at 3:37pm, RAC/LPN #B confirmed no medications documented for April 2013... It's like he/she never existed." The Operator failed to ensure all medications and bioligicals for #7 administered in accordance with medical care provider written orders and in accordance with professional standards of practice. - Review of record revealed #1 admitted to facility 7/26/12 with diagnoses of Alzheimer's, Diabetes, Cerebral artery disease, Hyperlipidemia, Hypertension, Hypothyroidism, Dementia, Vertigo, Hearing loss, and Gastroesophageal reflux disease. The 02/11/13 FCS (functional capacity screen) assessed #1 unable to perform medication and treatment management, with impaired communication, and with cognitive impairment related to short/long term memory, recall, and decision making. The medical record lacked an NSA (negotiated service agreement) to address medication management, the Resident Roster identified #1	S5300		

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S5300	Continued From page 48 with facility managed medication. By confidential interview an individual stated #1 with medical care provider order to receive one Exelon patch (medication for dementia) daily... on 3/25/13 at time of administration (8:00 am), the count on patches four long... Exelon patch on Resident and removed morning of 3/25/13 labeled "3/20/13"... the MAR (medication administration record) on 3/25/13 documented daily patches administered by CMA (certified medication aide) #H... these missed doses reported to previous Facility Nurse #I... on 3/26/13 the MAR documented by CMA #H to state Exelon patch not given 3/23 and 3/24 "could not find"... Facility Nurse #I notified the Dr., the Operator, completed medication error report and incident report... MAR then documented by CMA #H "3/22/13 Exelon Patch - error, was given". Review of Resident #1's MAR for March 2013 revealed Exelon Patch with administration initials for each day of month; circles around 3/22/13, 3/23/13, and 3/24/13, with "error" above 3/22/13... CMA #H documented three notes on back of MAR: 3/23/13 and 3/24/13 "Exelon Patch - could not find" followed by 3/22/13 "Exelon Patch - error was given" Resident record lacked documentation of nursing assessment of resident and lacked documentation of notification of physician. On 9/05/13 at 3:40pm when asked about drug error reports Operator stated " I don't know if LPN (Licensed Practice Nurse) #B did one...he/she would have that in a separate place. " 9/10/13 - 12:51pm - Requested Medication Error	S5300		

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S5300	Continued From page 49 Report, and/or Investigation/Resolution of missed doses 9/11/13 - 11:00am - No further information received from Operator On 9/10/13 at 1:46pm RAC (Resident assessment coordinator) LPN #B stated we wouldn't have any med error reports from March... we date the patch and initial patch when it is applied... The Operator failed to ensure all medications and biologicals administered to #1 in accordance with written medical care provider orders and in accordance with professional standards of practice. - Review of record revealed #3 admitted to facility 9/29/12 with diagnoses of Alzheimer's, Cerebral atrophy, Osteoporosis, Rheumatoid arthritis, Hypothyroidism, Constipation, Gastroesophageal reflux disease, and Constipation. The 02/11/13 FCS assessed resident #3 unable to perform medication and treatment management; with impaired cognition and communication and with impaired decision making. The NSA tated medication management services provided by facility staff. Comparison of MAR's (medication administration records) with written medical care provider orders revealed the following: 3/02/13 - 1700 - out of Namenda (to treat dementia), med not given 3/30/13 - out of Simethicone (to treat gas and bloating), med not given 3/31/13 - out of simethicone, med not given May 2013 - Physician's order to continue	S5300		

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S5300	Continued From page 50 Remeron (antidepressant) until Soltab (different preparation of Remeron) started, continue Aricept (to treat dementia) until Exelon (to treat dementia) started. MAR documented Remeron stopped on 5/10/13 and Soltab not started until 5/13/13, Aricept stopped 5/14/13 and Exelon not started until 5/17/13. On 9/05/13 at 4:07pm RAC LPN #B stated I am not remembering why that was done that way. On the following dates/times, Resident #3 refused all medications with no evidence of contact with Licensed nurse, no follow up documentation, alternative interventions, or care plan changes: 3/25/13 - 1700 and 1900 medications; 3/29/13 - 0800 and 1200 medications; 4/02/13 - All 0800 medications; 4/04/13 - 0800 medications; 4/10/13 - 1700 and 1900 medications; 4/27/13 - 0800 medications. On the following dates topical Seroquel (antidepressant/antipsychotic) administered for agitation with no evidence of contact with Licensed nurse, no follow up documentation, alternative interventions, or care plan changes: 7/04/13; 7/13/13; 7/14/13; 7/18/13; 7/23/13; 7/25/13; 8/01/13 - 0406; 8/01/13 - 21:30; 8/06/13; 8/07/13; 8/12/13; 8/14/13; 8/15/13 - 0600 and 22:00; 8/28/13. On 9/03/13 at 4:55pm, RN (registered nurse) #A and RAC/LPN #B stated the CMA calls the nurse when "PRN's" (as needed) given... per RN #A " I tell CMA to try warm towels and other interventions before a pill, if not effective give pill. " .. confirmed documentation not indicated in MAR's or Nursing Notes Nursing Notes lacked documentation of	S5300		

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S5300	Continued From page 51 symptoms, interventions attempted, or contact with Licensed Nurse for PRN administration of Seroquel. On 9/05/13 at 4:10pm, CMA #F confirmed no documentation or call to nurse for PRN's given. The Operator failed to ensure all medications and biologicals administered to resident #3 in accordance with written medical care provider orders and professional standards of practice. - Review of record revealed #4 admitted to facility 4/03/13 with diagnoses of Dementia, Agitation, Psychosis, Parkinson's, Muscle spasms, Insomnia, and Status post pneumonia. The 4/03/13 FCS assessed resident #4 in need of medication and treatment management. The 4/03/13 NSA stated medication management provided by facility staff. Review of MAR's (medication administration records) revealed discrepancies: September 2013 MAR documented Seroquel (antidepressant/antipsychotic) 25mg (milligrams) administered TID (three times daily) since 6/20/13; 6/19/13 - Medical record contained "Physician Visit" hand written by staff, signed by ARNP (advanced registered nurse practitioner) directing Seroquel increase to 25mg TID 6/19/13 - Medical record contained "Mobile Medical visit dictation" dictated and signed by same ARNP, stating Seroquel 25mg BID (twice daily) Medical record lacked clarification by Licensed Nursing staff of conflicting orders, signed by same practitioner, on same day, according to standards of practice.	S5300		

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S5300	Continued From page 52 By interview on 9/03/13 at 4:15pm RAC/LPN #B confirmed no clarification obtained for two conflicting orders signed by same ARNP on the same date. MAR's for this Resident documented missed doses of ordered medication: April 2013 - Seroquel 12.5mg circled not given 4/22/13 at 1200 and 1700, no documented explanation; Iron not administered twelve days - med not available; Klorkon not available x3 doses called pharmacy; May 2013 - all medications refused on 5/15/13 and 5/28/13 at 1200, and on 5/29/13 at 0800; no documentation of calls to nurse to get further directions or to allow care plan update; June 2013 - all medications refused 6/03/13 and 6//26/13 at 0800, 6/11/13 and 6/19/13 at 1200; Atarax not on hand, waiting on pharmacy 6/10, 6/11, 6/12, 6/13... order obtained to discontinue on 6/13/13. July 2013 - all medications refused 7/12/13 at 2000; August 2013 - all medications held at 1200 (due to nausea and vomiting, no call to nurse) On 9/05/13 at 2:33pm, 2:42pm, and 3:00pm RAC/LPN #B and RN #A confirmed no documentation available regarding missed medications, medication refusals and nurse contact for additional instruction. The Operator failed to ensure all medications and biologicals administered to Resident #4 in accordance with written medical care provider orders and professional standards of practice. - Review of record revealed #6 admitted to	S5300		

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S5300	Continued From page 53 facility 10/19/10 with diagnoses of Congestive heart failure, Renal insufficiency, Hypertension, Arrythmia, Chronic pain, and Degenerative joints lumbar spine. The 02/11/13 FCS assessed resident #6 unable to perform medication and treatment management. The 02/11/13 NSA stated medication management to be provided by facility staff. Review of the MAR's (medication administration records) and comparison with written physician orders revealed discrepancies: 4/16/13 - physician order - "DC (discontinue) Paxil - highly anticholinergic and no sign of depression per staff" April 2013 MAR documented Paxil administered daily from 4/01/13 to 4/18/13; arrow drawn and "D/C" next to administration initials; also hand written note on MAR stated "No continue, must verify with family member first" signed by LPN #B Next page of April MAR documents Paxil 10 mg po qd with arrows drawn over to the 18th to indicate start date of medications and documents daily doses given from 4/18/13 to 4/22/13 when resident #6 discharged. Paxil not DC'd on 4/16/13 as ordered On 9/05/13 at 3:05pm RAC/LPN #B stated I called family on 4/16/13 when Dr. DC'd med... said no they did not want #6 off that med... I restarted the Paxil on MAR but forgot to get physician's order to restart... then #6 discharged on 4/22/13 The Operator failed to ensure all medications and biologicals administered to Resident #6 in accordance with written medical care provider	S5300		

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S5300	Continued From page 54 orders, and professional standards of practice. - Focused Review Resident #9, admitted 01/11/11, identified on Resident Roster as receiving medication management. Review of MAR's for #9 revealed instances of medications not administered in accordance with written medical care provider orders: March 2013 - 3/04/13 - 1700 Colace (stool softener) not delivered by pharmacy yet, not given; April 2013 - 4/16/13 and 4/17/13 Ativan (to treat anxiety and depression) at 1400 daily circled as not given, no explanation on back of page; 4/08/13, 4/09/13, 4/10/13 Biotene mouthwash (to treat dry mouth) circled as not given, documented " not found " ; 4/17/13, 4/18/13, 4/20/13, 4/22/13 Fes Iron (to treat anemia) circled as not given, "med not in" all dates; May 2013 - 5/20/13 Multivitamin with minerals circled as not given; not in, called family documented June 2013 - 6/26/13 all medications refused 0800; 6/23/13 at 8:00am and 12:00pm, and 6/22/13 Combivent (to treat chronic obstructive respiratory disease) out of medication, not given July 2013 - 7/08/13 Pantaprazole (to treat gastric reflux) 40mg, pharmacy did not deliver, not given; 7/15/13 Senna S (stool softener) none in stock, not given; August 2013 - 8/02/13, 8/03/13, 8/04/13, 8/05/13 Refresh eye drops waiting on pharmacy, not given; Combivent 8/29/13 at 1700 and 2000, and on 8/30/13 at 0800 and 1200 not given On 9/05/13 at 1:50pm RN #A stated the family provided some of the medications for resident #9... had to wait for it to be brought in.	S5300		

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S5300	Continued From page 55 On 9/05/13 at 2:30pm and 2:40pm, RAC/LPN #B confirmed medications not given... confirmed no additional documentation to demonstrate follow-up and actions taken... Refresh eye drops were discontinued 7/30/13 and shouldn't have been on the August MAR, but hospital return 8/02/13 included them... Combivent, no reason for it not to be given, it was in the facility already from prior to hospitalization. The Operator failed to ensure all medications administered to Resident #9 in accordance with written medical care provider orders and professional standards of practice. For residents (#1, #3, and #4), and two focused review Residents with medication management (#9 and #6), the Operator failed to ensure all medications and biologicals administered to each Resident in accordance with a medical care provider's written order and in accordance with professional standards of practice.	S5300		
S5315 SS=F	26-42-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the home in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the home in separately locked compartments within a locked	S5315		

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S5315	Continued From page 56 medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the home. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(h) The census equalled five the sample included four Residents, and focused reviews completed on one current Resident and three discharged Residents. The facility identified all Residents as receiving medication management. Based on observation and interview, for all Residents of facility with medication management (#1, #2, #3, #4, #9), Licensed nurses and medication aides failed to ensure all controlled medications managed by the home in a separately locked compartment within a locked medication room or cabinet. Findings included:	S5315		

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S5315	Continued From page 57 - On 9/03/13 at 12:45pm upon entrance to facility, locked fire-safe box observed on kitchen counter next to stove top. At 12:55pm, locked fire-safe box remained on kitchen counter, with no persons in kitchen authorized to administer medications. At that time Operator confirmed that is the controlled medication box...confirmed box should not be outside the locked medication closet. On 9/03/13 at 1:15pm, CMA #D observed in and out of kitchen gathering trash, and outside to take trash out. The controlled medication box remained in the kitchen, now on the kitchen dining table. On 9/03/13 at 1:25pm, CMA #D stated not done with box yet... preparing to give #9 Ativan. Controlled medication box returned to locked cabinet. On 9/03/13 at 3:10pm, controlled medication box again out on kitchen counter as CMA #F administering medication in living room. Licensed nurses and medication aides failed to ensure all controlled medications managed by the home in a separately locked compartment within a locked medication room or cabinet.	S5315		
S5316 SS=D	26-42-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the home in sufficient detail for an accurate reconciliation.	S5316		

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S5316	Continued From page 58 (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(i) The census equalled five, the sample included five current Residents and three discharged Residents. The facility identified all current Residents as receiving medication management. Based on observation and interview, for one of eight Residents with medication management who used controlled medications (#8), Licensed nurses and medication aides failed to maintain records of destroyed medications according to acceptable standards of practice. Findings included:	S5316		

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S5316	Continued From page 59 On 9/04/13 at 4:30pm Facility RN (registered nurse) #A and RAC (Resident assessment coordinator)/ LPN (licensed practical nurse) #B stated " family of #1 arrived at facility 5/29/13 at 1300 to move #8 out. . .we knew two days before they were looking, but did not have notice of move... didn't have order to discharge with medications so we destroyed medications left in facility. " Note: physician order not required to release current medications to resident at discharge RN #A and LPN #B further stated " we place medications in kitty litter with liquid... we don't have a written policy and procedure, we use the pharmacy's policy and procedure. " Review of Resident #8's medical record: 5/29/13 Nursing Notes at 1300 " [Durable Power of attorney] here to move #1 to another facility, requesting medications be sent... faxed ARNP (Advanced registered nurse practitioner) for order " 5/29/13 Medical Care provider order signed by ARNP on 5/29/13 5/29/13 Nursing Notes at 1700 " left facility with family, no meds sent due to no order to do so " 5/30/13 Medication count sheet prescription Lortab 5/325 # xxxxx94, documented as administered at 0028 and 0500, amount remaining 11 tablets by CMA (certified medication aide) #J. Review of "Medication Returned or Destroyed Form" provided: 6/10/13 - prescription #xxxxx94 filled 4/29/13, with 11 tablets "destroyed"	S5316		

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S5316	Continued From page 60 "7" - same prescription number, with no fill date recorded, 10 tablets "destroyed" By interview on 9/10/13 at 12:09pm, RAC/LPN #B stated the incomplete entry dated "7" was for a bottle found in the medication closet by a medication aide in July... we don't know how it got there... LPN #B confirmed that same medication documented as destroyed on 6/10/13 with 11 tablets, and again on "7" with 10 tablets... stated I don't know what happened. By interview on 9/10/13 at 12:32pm, pharmacy staff reported that prescription #xxxxx94 filled one time, not two. On 9/10/13 at 1:46pm, RAC/LPN #B stated no written policy and procedure for destroying medications... we put them in gel cat litter... when full, we place in biohazard bag and place in the trash. Although the destroy document signed by RN #A and RAC/LPN #B indicated prescription bottle # xxxxx94 contents of 11 tablets destroyed on 6/10/13, that bottle later surfaced with 10 intact tablets inside. Licensed nurses and medication aides failed to destroy medications documented as destroyed for resident#1 on 6/10/13 and failed to maintain records of destroyed medications according to acceptable standards of practice.	S5316		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and	S5335		

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S5335	Continued From page 61 the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. This REQUIREMENT is not met as evidenced by: KAR 28-39-437(a)(b) The census equalled five the sample included four Residents. Based on observations and interviews, for all Residents, personnel, and visitors, the Operator failed to ensure the facility equipped and maintained to protect the health and safety of all individuals inside facility, in regard to front entry door required a key to open for all entering and exiting purposes. Findings included: - By observation on 9/03/13 at 6:20pm, front entry door locked with a dead bolt that prevented entry or exit. The door knob also contained a locking mechanism, and the door equipped with an alarm that sounded if door opened without first pushing a remote key fob silencer. Operator, RAC (resident assessment coordinator)/LPN(Licensed Practical Nurse) #B and RN(Registered Nurse) #A accompanied Surveyors to front door and summoned staff on duty in another room. CMA (certified medication aide) #E to front door in order to unlock dead bolt. CMA #E removed key from pocket and unlocked the round, shiny brass, dead bolt of door. On 9/03/13 at 6:20pm, Operator confirmed no	S5335		

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S5335	Continued From page 62 one could enter or leave in an emergency if the person carrying the key not available or lost the key or was compromised. By observation on 9/04/13 at 5:20pm, front door locked as visitor prepared to leave. CMA #F on duty summoned to front door to use key to unlock the dead bolt of door. On 9/04/13 at 5:20pm RAC/LPN #B confirmed the keyed deadbolt still in use... staff on duty had to open door... LPN #B confirmed the door knob (with inside button) capable of locking the door to prevent unauthorized entry... LPN #B confirmed remote key fob silencer still in use, and an alarm would sound if door opened before silencer activated to alert staff the door opened. At this time LPN #B directed CMA #F to place a piece of tape over the key hole, and LPN #B stated the dead bolt would not be used. For all Residents, personnel, and visitors, the Operator failed to ensure the facility equipped and maintained to protect the health and safety of all individuals inside facility when the Operator failed to ensure the facility equipped and maintained with a front door entry/exit that did not require a key to exit in an emergency.	S5335		
S5355 SS=E	28-39-437 Toilet Facilities (2) Toilet facilities. (A) There shall be at least one toilet room with a lavatory, and a shower or tub, for each five individuals living in the facility. (B) The facility shall provide grab bars or equivalent assistive devices at each toilet, tub, or	S5355		

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S5355	Continued From page 63 shower if required for resident safety. (C) Showers and tubs shall have nonslip surfaces or be provided with nonslip mats for resident safety. This REQUIREMENT is not met as evidenced by: KAR 28-39-437 The census equalled five, the sample included five current Residents and three discharged Residents. The facility identified three bathing/toileting areas in facility for Resident use. Based on observations and interviews, for one of three bathing/toileting areas (far West room used by #7 and #8), the Operator failed to ensure grab bars or equivalent assistive devices at each toilet, tub, or shower. Findings included: - By confidential interview, #7 reported a fear of falling after using the tub/shower in the far West room of facility... #7 reported there were no grab bars in or beside the tub/shower and rather than risk falling, he/she opted to clean self at the bathroom sink. By observation on 9/18/13 at 2:40pm, the bathing and toileting room of the far West double occupancy Resident room lacked grab bars or equivalent assistive devices at the tub/shower, and near the toilet. On 9/18/13 at 2:40pm RN #A confirmed there were no grab bars in this Resident room bathroom. On 9/18/13 at 5:50pm, RAC/LPN #B	S5355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087153	A. BUILDING: _____ B. WING _____	09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5355	Continued From page 64 acknowledged the lack of grab bars in the far West Resident use bathing and toileting area. The Operator failed to ensure grab bars or equivalent assistive devices at each toilet, tub, or shower.	S5355		